Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2355SNF	A. BUILDING _____ B. WING _____	C 07/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN AT CC HEALTH & REHAB	3050 N ORMSBY CARSON CITY, NV 89703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation initiated in your facility on April 21, 2009 and finalized on July 9, 2009, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. Complaint #NV00021481 was substantiated. See Tag Z230. Complaint #NV00021483 was unsubstantiated. Complaint #NV00021624 was unsubstantiated. Complaint #NV00021873 was substantiated. No deficiency was cited. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	Z 000		
Z230 SS=D	NAC 449.74469 Standards of Care A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant	Z230		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2355SNF	A. BUILDING _____ B. WING _____	C 07/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN AT CC HEALTH & REHAB	3050 N ORMSBY CARSON CITY, NV 89703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z230	Continued From page 1 to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439. This Regulation is not met as evidenced by: Based on record review, interviews and policy review the facility failed to implement care in accordance with the facility's policies and procedures for 1 of 8 residents. (Resident #4) Laboratory Tests - A laboratory test was not done in a timely fashion for a symptomatc patient with a urinary tract infection. (Resident #4) Severity 2 Scope 1	Z230		